Home and Community Based Waiver for Persons with Physical Disabilities

Definition

Nevada Medicaid's Home and Community Based Waiver for Persons with Physical Disabilities (PD) program offers home and community based services to recipients with physical disabilities. Recipients enrolled in this program would require institutional care without these waiver services.

Prior authorization

All services except case management must be prior authorized in order to receive payment.

Each recipient is assigned a case manager from the nearest Aging and Disability Services Division (ADSD) Office. The case manager requests prior authorization for all services (with the exception of case management) based on medical necessity as documented in the recipient's POC.

Verify prior authorization before providing service

Providers should verify that an approved prior authorization is in place before providing service. It is the ADSD case manager's responsibility to obtain prior authorization.

Approved authorization can be verified online through **EVS**, by calling **ARS at (800) 942- 6511** or by utilizing a **swipe card system**. Each of these methods is described in Chapter 3 of the Billing Manual on the Hewlett Packard Enterprise website (select "Billing Information" from the "Providers" menu).

Providers may also **contact the recipient's case manager** to verify that a service(s) has been prior authorized. Case managers may be reached at the following ADSD Offices:

Las Vegas
1860 East Sahara Avenue
Las Vegas, NV 89104
Phone: (702) 486-3545
Fax: (702) 486-3572
Email: adsd@adsd.nv.gov

Reno
445 Apple Street, Suite 104
Reno, NV 89502
Phone: (775) 688-2964
Fax: (775) 688-2969
Email: adsd@adsd.nv.gov

Carson City
3416 Goni Road, Suite D-132
Carson City, Nevada 89706
Phone: (775) 687-4210
Fax: (775) 687-0574
Email: adsd@adsd.nv.gov

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Elko

1010 Ruby Vista Drive, Suite 104
Elko, NV 89801
Phone: (775) 738-1966
Fax: (775) 753-8543
Email: adsd@adsd.nv.gov

Billing instructions

Submit claims to Hewlett Packard Enterprise. Claims must comply with the CMS-1500 Claim Form Instructions on the Hewlett Packard Enterprise website (at www.medicaid.nv.gov select "Billing Information" from the "Providers" menu).

Please note:

- **Field 21** (Diagnosis or nature of illness or injury) is required.
- In **Field 23**, you may only enter one authorization number per claim form.
- In **Field 24A**:
  - You may only bill for dates within the approved authorization period.
  - You may only bill for dates on which service was provided—per diem services may not be billed for days the recipient is not present in the facility.
  - You may bill up to one *calendar* week of service per claim line provided that service was rendered on each day and the week does not span calendar months, e.g., billing January 30, 2011 through February 5, 2011 on one claim line is unacceptable. One *calendar* week is defined as Sunday through Saturday—e.g., a Wednesday through Wednesday billing contains days from two different calendar weeks and cannot be billed on one claim line.
  - You may only bill one calendar month of service on a claim form, e.g., you may bill January 1 through January 30 on one claim form or February 1 through 28 on one claim form—but not January 15 through February 15.

As an example, the following table illustrates the dates to enter on each claim line in Field 24A when billing for services provided each day from January 25, 2016, through February 29, 2016. Two claim forms are required.

Form #	Line #	Dates to Bill
1	1	January 25-30
1	2	January 31
2	1	February 1-6
2	2	February 7-13
2	3	February 14-20
2	4	February 21-27
2	5	February 28-29

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In the un-shaded area of **Field 24D**, enter one of the codes below to bill for services rendered according to the recipient's POC.

- S5120 (chore services);15 minutes = 1 unit
- S5125 (attendant care service);15 minutes = 1 unit
- S5130 (homemaker service NOS);15 minutes = 1 unit
- S5150 (unskilled respite care);15 minutes = 1 unit
- S5160 (emergency response system installation and testing)
- S5161 (emergency response system monthly service fee)
- S5165 (home modifications per service)
- S5170 (home-delivered, prepared meal)
- S5199 (personal care item NOS, each)
- T1016 (case management)
- T2031 (Assisted Living waiver);paid per diem

- **Field 24E** (Diagnosis pointer) is required.

Effective with claims processed on or after December 21, 2015, provider type 58 is no longer required to submit an EOB or denial letter from the other health care (OHC) coverage provider.